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For a DRG payment case, administrative days are not paid until the case exceeds the high-cost outlier threshold for that case. If the hospital admission is solely for a stay until an appropriate sub-acute placement can be made, the hospital may be reimbursed at the Administrative Day per diem rate from the date of admission. The administrative rate is adjusted November 1.

For DRG exempt cases, administrative days are identified during the length of stay review process.

12. Short Stay Policy

Stays of less than, approximating, or exceeding 24 hours where an inpatient admission was not appropriate will be reimbursed on an outpatient basis. Stays of less than 24 hours involving the death of the patient, transfer to another acute care hospital, a delivery, or initial care of a newborn are reimbursed under the DRG payment methods.

13. Medicare Crossover Policy

Medicare crossovers refer to hospital patients who are eligible for Medicare benefits and Medical Assistance. For clients, the state considers the Medicare DRG payment to be payment in full. The state will pay the Medicare deductible and co-insurance related to the inpatient hospital services. Total Medicare and Medicaid payments to a provider can not exceed the DSHS's rates or fee schedule as if they were paid solely by Medicaid using the RCC payment method.

In cases where the crossover client's Part A benefits including lifetime reserve days are exhausted and the Medicaid outlier threshold status is reached, the state will pay for those allowed charges beyond the threshold using the outlier policy described above.

14. Fixed Per Diem Rate

A fixed per diem rate is used to reimburse for the Level B Acute PM&R and LTAC programs. The fixed per diem rate is established through identification of historical claims costs for the respective services provided. Annual cost inflation updates are made annually.

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15. Third-Party Liability Policy

For DRG cases involving third-party liability (TPL), a hospital will be reimbursed the lesser of the DRG billed amount minus the TPL payment amount or the applicable DRG allowed amount for the case minus the TPL payment amount. For RCC cases involving TPL, a hospital will be reimbursed the RCC allowed amount minus the TPL payment amount.

16. Day Outliers:

Section 1923(a)(2)(C) of the Act, requires the state to provide payment adjustment for hospitals for medically necessary inpatient hospital services involving exceptionally long length of stay for individuals under the age of six in disproportionate share hospitals and any hospital for a child under age one. A hospital is eligible for the day outlier payment if it meets the following:

a. Any hospital serving a child under age one or is a DSH hospital and patient age is 5 or under.

b. The patient payment is DRG.

c. The charge for the patient stay is under $33,000 (cost outlier threshold).

d. Patient length of stay is over the day outlier threshold for the applicable DRG.

The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

The Day Outlier Payment is based on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate. Day outliers will only be paid for cases that do not reach high cost outlier status. A patient's claim can be either a day outlier or a high cost outlier, but not both.

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17. Trauma Care Enhancement

The trauma Care enhancement is contingent upon State legislative appropriation of funds to the State Department of Health. Because the State funding can change during a year or in different years, so can the enhancement. The enhancement consists of paying a multiple of the standard DRG or RCC payment for trauma care services rendered. Currently the multiple is three times the standard payment. The RCC enhanced payment can be no more than the billed charges on the claim. The DRG enhanced payment can exceed the billed charges, but the aggregate of payments for all DRG paid claims cannot exceed the aggregate that Medicare would pay for the same DRG claims in the year.

D. DRG COST-BASED RATE METHOD

The DRG cost-based rate is a calculated hospital specific dollar amount that is multiplied by the applicable DRG weight to produce the DRG payment. The rate has three components (operating, capital and direct medical education). The rate is established on the basis of hospital's average cost for treating a Medicaid patient during a base period. This amount is adjusted for the hospital's case mix and updated for inflation.

1. Base Period Cost and Claims Data

The base period cost data for the rates are from hospitals' Medicare cost reports (Form HCFA 2552) for their fiscal year (FY) 1998. Cost data that was desk reviewed and/or field audited by the Medicare intermediary before the end of the rebasing process was used in rate setting when available.

Three categories of costs (total costs, capital costs, and direct medical education costs) are extracted from the HCFA 2552 for each of the 38 allowed categories of cost/revenue centers used to categorize Medicaid claims.

Nine categories are used to assign hospitals' accommodation costs and days of care, and 29 categories were used to assign ancillary costs and charges. Medicaid paid claims data for each hospital's FY 1998 period are extracted from the state's Medicaid Management Information System (MMIS).

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Department of Health Composite Hospital Abstract Reporting System (CHARS) claims representative of services covered and provided by Healthy Options managed care plans are also extracted. Line item charges from claims are assigned to the appropriate 9 accommodation and 29 ancillary cost center categories and used to apportion Medicaid costs. These data are also used to compute hospitals' FY 1998~~3~~ case-mix index.

2. Peer Groups & Caps

The Medical Assistance Administration's (MAA's) peer group methodology for peer groups A and B is aligned with that of Washington State Department of Health's (DOH) and is adopted for rate-setting purposes. MAA's peer grouping has four classifications: Group A, which are rural hospitals paid under an RCC methodology; Group B, which are urban hospitals without medical education programs; Group C, which are urban hospitals with medical education programs; and Group D, which are specialty hospitals. DOH's peer group 3 combines the hospitals located in MAA's peer groups C and D.

Indirect medical education costs are removed from operating and capital costs, and direct medical education costs are added. Peer group caps for peer groups B and C are established at the 70th percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs. In computing hospitals' rates, hospitals whose costs exceed the 70th percentile of the peer group are re-set at the 70th percentile cap. The hospitals in peer group D are exempted from the caps because they are specialty hospitals without a common peer group on which to base comparisons.

Changes in peer group status as a result of DOH and MAA approval or recommendation are recognized. However in cases where post-rate calculation corrections or changes in individual hospital's base-year cost or peer group assignment result in a change in the peer group cost at the 70th percentile, and thus have an impact on the peer-group cap, the cap is updated only if it result<u>s</u> in a 5.0 percent or greater change in total Medicaid payment levels.

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3. Conversion Factor Adjustments

Indirect medical education costs are added back into costs before application of any inflation adjustment. A 0.008219 percent per day inflation adjustment (3.0 percent divided by 365 days) is used for hospitals that have their fiscal year ending before December 31, 1998~~3~~. A 9.1086 percent inflation adjustment is used for the period from January 1, 1999 to October 31, 2001.

Annually ~~each year~~ for medical care services all conversion factors are increased by a predetermined inflation factor.

4. Medicaid Cost Proxies

In some instances, hospitals had Medicaid charges (claims) for certain accommodation or ancillary cost centers that are not separately reported on their Medicare cost report. To ensure recognition of Medicaid related costs, proxies are established to estimate these costs. Per diem proxies are developed for accommodation cost centers; RCC proxies for ancillary cost centers.

5. Case-Mix Index

Under DRG payment systems, hospital costs must be case-mix adjusted to arrive at a measure of relative average cost for treating all Medicaid cases. A case-mix index for each hospital is calculated based on the Medicaid cases for each hospital during its FY 1998~~3~~ cost report period.

6. Indirect Medical Education Costs

An indirect medical education cost is established for operating and capital components in order to remove indirect medical education related costs from the peer group caps. To establish this factor, a ratio based on the number of interns and residents in approved teaching programs to the number of hospital beds is multiplied by the Medicare's indirect cost factor of 0.579. The resulting ratio is multiplied by a hospital's operating and capital components to arrive at indirect medical education costs for each component.

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The indirect medical cost is trended forward using the same inflation factors as apply to the operating and capital components and added on as a separate element of the rate as described in paragraph 7.

7. Rate Calculation Methodology

Step 1: For each hospital the base period cost data are used to calculate total costs of the operating, capital, and direct medical education cost components in each of the nine accommodation categories. These costs are divided by total hospital days per category to arrive at a per day accommodation cost. The accommodation costs per day are multiplied by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

Step 2: The base period cost data are also used to calculate total operating, capital and direct medical education costs in each of the 29 ancillary categories. These costs are divided by total charges per category to arrive at a cost-to-charge ratio per ancillary category. These ratios are multiplied by MMIS Medicaid charges per category to arrive at total Medicaid ancillary costs per category for the three components.

Step 3: The Medicaid accommodation and ancillary costs are combined to derive the operating, capital and direct medical education's components. These components are then divided by the number of Medicaid cases to arrive at an average cost per admission.

Step 4: The three components' average cost per admission are next adjusted to a common fiscal year end (December 31, 1998~~3~~) using the appropriate DRI-HCFA Type Hospital Market Basket update and then standardized by dividing the average cost by the hospital's case-mix index.

Step 5: The indirect medical education portion of operating and capital is removed for hospitals with medical education programs. Outlier costs were also removed. For hospitals in Peer Group B and C, the three components aggregate cost is set at the lesser of: hospital specific aggregate cost or the peer group cap aggregate cost.

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Step 6: The resulting respective costs with the indirect medical education costs and an outlier factor added back in are next multiplied by the DRI-HCFA Type Hospital Market Basket update for the period January 1, 1999 through October 31, 2001. The outlier set aside factor is then subtracted to arrive at the hospital's January 1, 2001 cost-based rate. This cost-based rate is multiplied by the applicable DRG weight to determine the DRG payment for each admission.

Those in-state and border area hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

8. Border Area Hospitals Rate Methodology

Border area hospitals include facilities located in areas defined by state law as: Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, and The Dalles; Idaho - Couer d'Alene, Lewiston, Moscow, Priest River and Sandpoint.

These hospitals' cost-based rates are based on their FY 1998~~3~~ Cost Reports and FY 1998~~3~~ claims, if available. Those border area hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

9. New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to January 1, 2001. A change in ownership does not constitute the creation of a new hospital. New hospitals' cost-based rates are based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

10. Change in ownership

When there is a change in ownership, and/or the issuance of a new federal identification, the new provider's cost-based rate is the same rate as the prior owner's. Depreciation and acquisition costs are recaptured as required by Section 1861 (V) (1) (0) of the Social Security Act.

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Mergers of corporations into one entity with subproviders receive a blended rate based on the old entities rates. The blended rate is weighted by admission for the new entity.

E. RCC RATE METHOD

The RCC payment method is used to reimburse Peer Group A hospitals for their costs and other hospitals for certain DRG exempt services as described in Section C.8. The RCC ratio for out-of-state hospitals is the average of RCC ratios for in-state hospitals. The RCC ratio for in-state and border area hospitals which the State determines have insufficient data or Medicaid claims to accurately calculated an RCC ratio, is also the average of RCC ratios for in-state hospitals.

Hospital's RCC ratios are updated annually with the submittal of new HCFA 2552 Medicare cost report data. Increases in operating expenses or total rate-setting revenue attributable to a change in ownership are excluded prior to computing the ratio.

F. DISPROPORTIONATE SHARE PAYMENTS

As required by Section 1902(a)(13)(A) and Section 1923(a)(1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment for eligible hospitals. To be eligible for any disproportionate share program a hospital must meet the Medicaid one percent utilization to qualify. A hospital will receive any one or all of the following disproportionate share hospital (DSH) payment adjustments if the hospital meets the eligibility requirements for that respective DSH payment component. All the DSH payments will not exceed the state's DSH allotment.

To accomplish this goal, it is understood in this State Plan, that the State intends to adjust their DSH payments to ensure that the costs incurred by Medicaid and uninsured patients are covered to the maximum extent permitted by the State's DSH allotment.

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In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost.

Cost defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan, plus the cost of services to indigent and uninsured patients, less any cash payments made by them.

We will not exceed the DSH State-wide allotment nor allow a hospital to exceed the DSH limit. The following clarification of our process explains our precautionary procedures. All the DSHS's DSH programs' payments are prospective payments and these programs are the LIDSH, MIDSH, GAUDSH, SRHAPDSH, THAPDSH, STHFPDSH, CTHFPDSH and PHDDSH.

DSH programs for which payments are fixed represent 84 percent of our disproportionate share payments to hospitals. The other two DSH programs, MIDSH and GAUDSH, are paid on a by claims basis. To adjust for these unknowns in the MIDSH and GAUDSH we use claims data and estimate what expected expenditures would be paid during the current state fiscal year. This estimate then becomes a part of the hospitals 100 percent limit.

The Medical Assistance Administration (MAA) will monitor payments monthly. Each month MAA will receive an MI Summary Report and GAU Summary Report from our Medicaid Management Information System (MMIS) identifying expenditures paid to each hospital under the MIDSH and GAUDSH programs. Each month we will also receive the DSHS Allotment/Expenditure Transaction Register identifying the remaining DSH program expenditures. The figures in these reports will be accumulated monthly to determine that hospitals have not exceeded the DSH limit.

If a hospital reaches its DSH limit, payments will be stopped. The Department of Social and Health Services (DSHS) will determine the extent to, and how each, DSH program is funded. Any specific guidance that may be provided by the State legislature will be followed by DSHS.

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If a hospital exceeds it's DSH limit the DSHS will recoup the DSH payments in the following program order, PHDDSH, THAPDSH, CTHFPDSH, STHFPDSH, SRHAPDSH, MIDSH, GAUDSH AND LIDSH. For example, if a hospital were receiving payments from all DSH programs, the over payment adjustment would be made in PHDDSH to the fullest extent possible before adjusting THAPDSH payments. If the DSH state-wide allotment is exceeded we will similarly make appropriate adjustments in program order shown above.

1. Low-Income Disproportionate Share Hospital (LIDSH) Payment

Hospitals shall be deemed eligible for a LIDSH payment adjustment if:

a. The hospital's Medicaid inpatient utilization rate (as defined in Section 1923(b)(2)) is at least one standard deviation above the mean Medicaid inpatient utilization rate of hospitals receiving Medicaid payments in the State; or,

b. The hospital's low-income utilization rate (as defined in Section 1923 (b) (3)) exceeds 25 percent.

c. Except as specified in Section 1923 (d) (2), no eligible hospital may receive a disproportionate share payment adjustment unless the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to Medicaid services.

Hospitals deemed eligible under the above criteria shall receive disproportionate share payment amounts which in total will equal the funding set by the State's appropriations act for LIDSH. The process of apportioning payments to individual hospitals is as follows:

A single base payment is selected that distributes the total LIDSH appropriation. For each hospital, the base payment is multiplied by the hospitals low income utilization factor standardized to one, by the hospital's most recent Fiscal Year case mix index by the hospital's subsequent year's estimated admissions of Title XIX eligibles. Results for all hospitals are summed and compared to the appropriated amount.

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If the sum differs from the appropriated amount, a new base payment figure is selected. The selection of base payment figures continues until the sum of the calculated payment equals the appropriated amount. The appropriation amount may vary from year to year. Each hospital's disproportionate share payment is made periodically.

2. Medically Indigent Disproportionate Share Hospital (MIDSH) payment

Effective July 1, 1994, hospitals shall be deemed eligible for a MIDSH payment if:

a. The hospital is an in-state or border area hospital; and,

b. The hospital provides services to low-income, Medically Indigent (MI) patients. MI persons are low-income individuals who are not eligible for any health care coverage and who are encountering an emergency medical condition; and,

c. The hospital has a low-income utilization rate of one percent or more; and,

d. The hospital has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are eligible for Medicaid, provided the hospital offers non-emergency obstetric services to the general population and is not a rural hospital.

Hospitals qualifying for MIDSH payments will receive a periodic per claim payment. The payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment. The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals. The equivalency factor ensures that MIDSH payments will equal the State's estimated MIDSH appropriation level.

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Effective for admissions on or after July 1, 1994, the payment is reduced further by multiplying it by 97 percent. The resulting payment is directly related to the hospital's volume of services provided to low-income MI patients. This payment reduction adjustment is applied to the MIDSH methodology established and in effect as of September 30, 1991 in accordance with Section 3(b) of the "Medicaid Voluntary Contributions and Provider-Specific Tax Amendment of 1991."

3. General Assistance Unemployable Disproportionate Share Hospital (GAUDSH) payment

Effective July 1, 1994, hospitals shall be deemed eligible for a GAUDSH payment if:

a. The hospital is an in-state or border area hospital; and,

b. The hospital provides services to low-income, General Assistance Unemployable (GAU) patients. GAU persons are low-income individuals who are not eligible for any health coverage and who are encountering a medical condition; and,

c. The hospital has a low-income utilization rate of one percent or more; and,

d. The hospital has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are eligible for Medicaid, provided the hospital offers non-emergency obstetric services to the general population and is not a rural hospital.

Hospitals qualifying for GAUDSH payments will receive a periodic per claim payment. The payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment. The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals.

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The equivalency factor insures that GAUDSH payments will equal the State's estimated GAUDSH appropriation level.

4. Small Rural Hospital Assistance Program Disproportionate Share Hospital

Effective July 1, 1994, hospitals shall be deemed eligible for a Small Rural Hospital Assistance Program Disproportionate Share Hospital (SRHAPDSH) payment if:

a. The hospital is an in-state (Washington) hospital; and

b. The hospital provides at least one percent of its services to low-income patients in rural areas of the state; and

c. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 licensed beds and located in a city or town with a non-student population of 13,000 or less; and

d. The hospital qualifies under Section 1923(d) of the Social Security Act.

Hospitals qualifying for SRHAPDSH payments started earning payments under this plan July 1, 1994, from a legislatively appropriated pool. The apportionment formula is based on each SRHAPDSH hospital's Medicaid and other low-income reimbursement during the most current state fiscal year less any low income disproportionate share payments.

To determine each hospital's percentage of Medicaid payments, the sum of individual hospital payments is divided by the total Medicaid payments made to all SRHAPDSH hospitals during the most currently available state fiscal year. The percentage is then applied to the total dollars in the pool to determine each hospital's payment. Each Public Hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them.

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Dollars not allocated due to the limitation imposed by the 100 percent of the projected cost of care for Medicaid and Uninsured Indigent Patient ceiling are reallocated to the remaining hospitals in the SRHAPDSH pool. The payments are made periodically. SRHAPDSH payments are subject to federal regulation and payment limits.

5. Teaching Hospital Assistance Program Disproportionate Share Hospital (THAPDSH)

Effective July 1, 1994, teaching hospitals shall be deemed eligible for the Teaching Hospital Assistance Program Disproportionate Share Hospital (THAPDSH) program if they meet the following eligibility standards:

a. The hospital must be a Washington State university hospital; and

b. The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services. This standard does not apply to hospitals which do not offer non-emergency obstetric services to the general population; and

c. The hospital must have a Medicaid low-income utilization of 20 percent or above.

Hospitals qualifying for THAPDSH payments started receiving payments under this plan July 1, 1994. THAPDSH payments will be made from a legislatively appropriated pool and are equally divided between THAPDSH qualified hospitals.

6. State Teaching Hospital Financing Program Disproportionate Share Hospital:

Effective June 15, 1997, hospitals shall be deemed eligible for a State Teaching Hospital Financing Program Disproportionate Share Hospital (STHFPDSH) if:

a. The hospital provides at least 20 percent of its services to low-income patients; and,

b. The hospital is a Washington state-owned university hospital (border area hospitals are excluded); and,

c. The hospital provides a major medical teaching program, defined as a hospital with more than 100 residents or interns; and,

d. The hospital qualifies under section 1923(d) of the Social Security Act.

The hospitals deemed eligible under the above criteria shall receive a periodic disproportionate share payment amount of the legislatively appropriated pool only for disproportionate share payment to state and county teaching hospitals. The STHFPDSH payments may vary and are contingent upon the federal allotment for state disproportionate share cap.

7. County Teaching Hospital Financing Program Disproportionate Share Hospital:

Effective July 1, 1993, hospitals shall be deemed eligible for a County Teaching Hospital Financing Program Disproportionate Hospital (CTHFPDSH) payment if:

a. The hospital provides at least 25 percent of its services to low-income patients;

b. The hospital is a county hospital in Washington State (border area hospitals are excluded);

c. The hospital provides a major medical teaching program, defined as a hospital with more than 100 residents or interns; and,

d. The hospital qualifies under section 1923 (d) of the Social Security Act.

The hospitals deemed eligible under the above criteria shall receive a periodic disproportionate share payment amount of the legislatively appropriated pool only for disproportionate share payments to state and county teaching hospitals. The CTHFPDSH payments may vary and are contingent upon the federal allotment for state disproportionate share cap.

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8. Public Hospital District Disproportionate Share Hospital:

Effective June 1, 1995, hospitals shall be deemed eligible for a Public Hospital District Disproportionate Hospital (PHDDSH) payment if:

a. The hospital provides at least 1 percent of its services to low-income patients;

b. The hospital is a Public District Hospital in Washington State (as of June 15, 1997, border area public hospitals are included);

c. The hospital qualifies under section 1923 (d) of the Social Security Act.

Public hospital districts are organized and exist as a result of The Washington legislature authorization of public hospital districts. Public hospital districts are authorized to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons. Border area public hospitals are border area hospitals owned by a public corporation or public hospital district in a border area state.

Hospitals that apply and are deemed eligible under the above criteria shall receive a disproportionate share payment for hospital services during the State's fiscal year that in total will not exceed 100 percent of cost as defined in Section 1923(g) of the Social Security Act. Each hospital will receive a payment based on the factors specified in Section 1923(g) of the Social Security Act.

Hospitals deemed eligible under the above criteria shall receive a periodic disproportionate share payment amount. The pool for PHDDSH payments is legislatively appropriated. The PHDDSH payments may vary and are contingent upon the federal allotment for state disproportionate share cap.

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G. CUSTOMARY CHARGE PAYMENT LIMITS

As required by 42 CFR 447.271, total Medicaid payments to each hospital for inpatient hospital services to Medicaid recipients shall not exceed the hospital's customary charges to the general public for the services. The state may recoup amounts of total Medicaid payments in excess of such charges.

H. ADMINISTRATIVE POLICIES

1. Provider Appeal Procedure

A hospital may appeal any aspect of its Medicaid payment rates by submitting a written notice of appeal and supporting documentation to the DSHS (Medical Assistance Administration) except that no administrative appeals may be filed challenging the method described herein. The grounds for rate adjustments include, but are not limited to, errors or omissions in the data used to establish rates, changes in capital costs due to licensing or certification requirements, and peer group change recommended by the Medical Assistance Administration.

Additional documentation, as specified by DSHS, may be required in order to complete the appeal review. DSHS (Medical Assistance Administration) may have an audit and/or desk review conducted if necessary to complete the appeal review. A hospital may appeal its rates by submitting a written notice of appeal to the Rate Analysis Section, Medical Assistance Administration (MAA).

Unless the written rate notification specifies otherwise, a hospital rate appeal requesting retroactive rate adjustments must be filed within sixty days after being notified of an action or determination the hospital wishes to challenge. The notification date of an action or determination is the date of the written rate notification letter. A hospital rate adjustment appeal, filed after the sixty-day period described in this subsection shall not be considered for retroactive adjustments.

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When an appeal is made, all aspects of this rate may be reviewed by DSHS. Unless the written rate notification specifies otherwise, increases in rates resulting from an appeal filed within 60 days after the written rate notification letter that the hospital is challenging shall be effective retroactively to the effective date of the rate change as specified in the notification letter. Increases in rates resulting from a rate appeal filed after the 60 day period or exception period, shall be effective the date the appeal is filed with DSHS. Appeals resulting in rate decreases shall be effective on the date specified in the appeal decision notification.

A hospital may request a Dispute Conference to appeal an administrative review decision. The conference will be conducted by the MAA's Assistant Secretary or designee. The hospital must submit a request for a conference within 30 days of receipt of the administrative review decision. The Dispute Conference decision is the state agency's final decision regarding rate appeals.

2. Uniform Cost Reporting Requirements

Hospitals are required to complete and submit a copy of their annual Medicare cost reports (HCFA 2552), including Medicaid related data, to the MAA. In addition, hospitals are required to submit other financial information as required by the MAA to establish rates.

3. Financial Audit Requirements

The MAA will have cost report data used for rate setting periodically audited.

In addition, hospital billings and other financial and statistical records will be periodically audited.

4. Rebasing & Recalibration

DSHS will rebase the Medicaid payment system on a periodic basis using each hospital's cost report for its fiscal year ending during the base year selected for the rebasing.

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I. PROPORTIONATE SHARE PAYMENTS FOR STATE AND COUNTY TEACHING HOSPITALS

1. A proportionate share pool is created each state fiscal year for supplemental payments to eligible providers of Medicaid patient services. Eligible providers are King County owned or Washington State operated teaching hospitals.

2. Funds retained will be used to improve health care services to low income patients.

3. The supplemental payments made to eligible teaching hospitals are subject to prior federal approval for obtaining federal matching funds for the supplemental payments. The supplemental funds are subject to the federal Medicare upper payment limit for hospital payments. The Medicare upper limit analysis will be performed prior to making the supplemental payments.

4. The ProShare payment for each payment year is determined as follows:

   The cumulative difference between covered Title XIX inpatient charges and Title XIX payments and third party liability payments for all eligible hospitals during the most recent Federal Fiscal year becomes the total ProShare payment that will be distributed during the payment year. The source of the charge and payment data is our Medicaid Management Information System (MMIS) for the base year. Only charges and payments for inpatient hospitals services are included in the computation and the base year determined amount is not inflated to the payment year.

5. Payments will be distributed to the eligible teaching hospitals in proportion to Medicaid Charges Factor, the dollars resulting from the difference between Hospital Allowed Charges and Title XIX payment, including third party liability. The Medicaid Allowed Charges factor is specific to the base year. The supplemental payment will be at least annually during each federal fiscal year.

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F. CRITICAL ACCESS HOSPITAL (CAH) PROGRAM

1. Critical Access Hospital (CAH) program means a Title XIX inpatient and outpatient hospital reimbursement program through which hospitals meeting the Medicare qualifications for CAH designation are approved by the Department and reimbursed for Title XIX services through a cost settlement method.

2. Through this cost settlement payment method hospitals participating in the state's Title XIX CAH program receive prospective payment for outpatient hospital services based on an Outpatient Departmental Weighted Cost-to-Charge (ODWCC). Post-period cost settlement is then performed subsequent to the hospital fiscal year (HFY) end using HFY claims data and data from the HCFA 2552 Medicare Cost Report.